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Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund 2026-27 Narrative return - Dorset

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

Adapt as necessary	**HWB area 1**	**HWB area 2**
HWB	Dorset	
ICB	Dorset	
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1. **Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.**

Better Care Fund Planning 2026/27

Dorset's approach to the Better Care Fund (BCF) in 2026/27 is to maximise prevention and independence, using BCF investment to strengthen locally based approaches that align to Neighbourhood Health initiatives. This will enable more people to be supported well at home and in their communities. We will continue to build on two system-wide programmes: Future Care, which is transforming urgent, emergency and intermediate care end-to-end, and the development of Integrated Neighbourhood Teams (INTs) that bring together primary care, community services, adult social care, VCSE partners and housing to coordinate proactive, person-centred support.

Key BCF-funded schemes that underpin this include Disabled Facilities Grants delivered through Dorset Accessible Homes Service; the jointly commissioned Integrated Community Equipment Service (ICES) which is accessible by Health and Social Care staff, enabling minor adaptations and Technology Enabled Care (TEC) to be made available to Dorset's residents. During 2025/26 ~2,200 people benefited from a largely digitised careline offer and a hands-on 'TEC Lounge' to help practitioners and residents trial solutions.

Our plan for this year is well aligned to the NHS Dorset Five Year Commissioning Plan.

Carers

The BCF will continue to support unpaid carers across Dorset. Our longstanding offers that provide respite, peer support and information, advice and guidance continue, however, we are also developing pathways that offer more preventative and proactive support, ranging from self-help plans and information support areas, all age service that supports young carers, and piloting support for carers for pre and post hospital admission.

Prevention and VSCE Partnership

We will continue to invest BCF resource to the Dorset Integrated Prevention Partnership (DIPP) – a suite of VCSE-led services spanning community connectors, volunteer response, social reablement/crisis support and targeted housing/tenancy support – to intervene earlier and reduce escalation. Our commissioning will maintain the strategic 'left' shift to increase preventative approaches, and those that enable the least restrictive care options. e.g moving from bed-based to home-based care, enhanced by community offers.

Intermediate Care

In Intermediate Care, following phase one of our Future Care programme, we will continue to embed discharge-to-assess principles and continue to invest our BCF into health and social care staffing to support and manage pathways. We will further develop closer working of these staffing teams, along with care providers, at a more local level to enhance our Locality level Clinical wrap-around support and MDT arrangements. This will better manage and oversee people who are being supported by home-based intermediate care (HBIC), and expand the cohort who can access these services, in particular, those with more complex and higher levels of need.

The Trusted Assessors and Reablement and Recovery & Community Resilience services will continue to support swifter discharges home from hospital, and focus on recovery at home with strengths-based approaches to ensure Dorset residents maximise independence, before long-term care options are considered. During 2025/26 improvements to HBIC pathways has resulted in support for higher levels of need, as the number of people supported by larger care packages to return straight home has increased.

In respect of bedded intermediate care, similar work is needed to ensure people with higher level/more complexity of need can move out of the acute setting sooner – we are utilising

NHSE best practice guidance to support and inform the requirements of the enhanced resources we need to develop.

As we move into the next phase of UEC transformation, we will continue to develop step-up/step-down pathways with wider System resources such as Urgent Community Response and the Care Coordination Hub. Identifying opportunities to align to Dorset's Neighbourhood Health programme is key.

Demand & Capacity

Through the Future Care Programme we have improved insights into demand and capacity by intermediate care pathway. This is being embedded into System-wide governance to improve visibility and performance monitoring/management.

In line with the Future Care projected benefits, as anticipated, we have seen a shift in demand from Pathway 2 (P2) / intermediate bedded care to Pathway 1 (P1) / HBIC. However, P1/HBIC demand has increased more than anticipated, which at times leads to longer waits for people ready to leave hospital, particularly for those needing larger care packages, despite the improvements to efficacy and flow. During 26/27 we plan to address this and will develop our P1/HBIC offer to strengthen clinical and MDT oversight and expand options to enable more enhanced needs, such as night-time and more time -intensive care to be supported.

P2 capacity is sufficient to meet demand, but we need to improve length of stay to optimise flow and reduce waiting times. Over the last year we have been able to reduce reablement bedded capacity due to improvements in P1 flow and P2 length of stay.

In respect of Pathway 3 (P3) capacity we have sufficient capacity but are working on increasing visibility of demand to ensure we have the capacity available at the right time to minimise the time it takes to move people between settings. Enhancing our specialist bed provision is another area of focus in the coming year to improve current performance.

Links to Neighbourhood Health Programme

Dorset Place was successful in becoming one of the 43 Places in England to participate in the National Neighbourhood Health Implementation Programme (NNHIP).

This has provided the opportunity to accelerate more proactive working within each Integrated Neighbourhood Team (INT). Currently a focus on interventions for those who are moderately or severely frail and at high risk of falls has been agreed as a priority cohort. Interventions include proactive, personalised care-planning, medicines optimisation and care co-ordination/navigation, which we expect to reduce non-elective admissions and ED attendances.

As we learn about new ways of working and the associated outcomes, we will be considering how we improve joint commissioning of proactive, preventative care, alongside intermediate care within Dorset Place.

The Health and Wellbeing Board, Place-Based Partnership and joint coordination of the BCF will enable Dorset to realise the outcomes aligned to the neighbourhood plans.

26/27 Changes to our investments

There is one substantial change to our investments this year; during 25/26 we reduced the number of reablement beds from 30 to 12. The money released here has been used to invest into the one-off Future Care Transformation resources which will enable us to unlock system wide operational benefits. We anticipate this money being released for new service investment from 27/28.

Governance

Governance will remain joint via the Health & Wellbeing Board with day-to-day BCF scheme management and monitoring overseen collaboratively between Dorset Council and NHS Dorset Lead Officers.

2. **Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

Non-elective admissions (for those 65 years old and over) and delayed discharges:

To ensure our targets reflect both system pressures and improvement opportunities, our 2026/27 metric goals have been set by reviewing the 2025/26 activity data. Periods in 2025/26 saw surge of activity above the forecast plan, this has been reflected in our planning for 2026/27.

Future Care's system diagnostic highlighted that up to a third of admissions from ED could be safely avoided with different services and better coordination, and that average waits for people not discharged on the day they are medically fit are materially above the national average; it also identified sizeable opportunity to reduce length of stay in intermediate care beds. We are therefore setting stretching yet realistic trajectories for non-elective admissions (65+) and delayed discharges that assume matured alternatives to admission, strengthened P1 (home-first) pathways, and improved transfer-of-care coordination. Operationally, we will use system visibility tools and shared dashboards to track run-rate against plans, LOS, conversion rates from P1/P2, and discharge delays by reason, with weekly review at cross-organisational forums (including the Transfer of Care Hub). Local goals in the Excel return are informed by local actual activity data from 2025/26, expected efficiency from Future Care workstreams, and demand/capacity profiling which anticipates a shift from P2 to P1 volumes as efficacy improves. We will triangulate intelligence from DiiS population-health data, provider performance, and brokerage/market signals to course-correct in-year. Our methodology and assumptions align to the national Metrics Handbook and planning guidance, ensuring local ambitions are evidence-based and deliverable within the financial and operational context for 2026/27.

Preventing avoidable long-term care home admissions

During 2026/27 we will continue to monitor long-term residential admissions and further develop strategies and initiatives to prevent and delay the need for residential care. These include:

- Strengthening our Prevention and Early Intervention offer by making reablement support more widely available as part of our community/front door offer. This includes opportunities to introduce equipment and Technology Enable Care as

alternatives to ‘hands-on’ care, where appropriate. Whilst funded from outside BCF, we have included theses as new BCF schemes from 26/27 given the clear links to BCF objectives.

- Stronger home-based intermediate care offer that includes therapy-led, goals focussed reablement, either on discharge from hospital, or to prevent admission.
- DFGs will be used to enable more people to remain independent in a home of their own home, for longer.
- Extra Care Housing is available across several sites in Dorset that is providing an alternative to residential care, that enables more frequent of higher levels of care to be met. The Council has longer term plans to further expand Extra Care Provision across Dorset, utilising Council sites for development. Whilst funding is outside of BCF schemes, this approach is a key enabler to reducing reliance on long-term care home placements.

The metrics for measuring our performance in residential admissions is laid out in our Numerical Template, and the Council monitor performance monthly via corporate governance reporting This year we have applied quarterly targets on a more even spread, with slight variation applied for seasonal pressures.

Via the Future Care Programme we have focussed more attention to improving reablement outcomes by:

- Deployment of a Reablement App, alongside leadership of a new Occupational Therapist, within our Lead Reablement Provider. This is embedding a goals focusses approach, and will continue to increase the effectiveness of the reablement intervention, increasing longer-term independence. In particular, this should increase the proportion of older people who remain at home 12 weeks after discharge.

- Measuring the average weekly effectiveness (hours of care reduced) of all Reablement providers, and introducing this as a leading Key Performance Indicator to our contracts. the impact of Phase 1 of the Future Care programme has improved HBIC provider performance, reducing length of stay, and increasing effectiveness. Despite needing to reduce some funding during 25/26, approx. 7 more people enter HBIC support each week.

3. **Please provide a short explanation of the planned impact of BCF funding on achievement of goals.**

BCF funding for 2026/27 will continue to be deployed across Dorset schemes; many of them focus on prevention and independence in the community, already well-aligned to intermediate care models, and well placed for closer working with neighbourhood health as the Dorset model develops. Many schemes support more than one of the overall BCF goals of:

- Reducing Non-Elective Admissions
- Reducing Delayed Discharges
- Improving Reablement Outcomes and
- Reducing long term care admissions

We anticipate the impact of funding across the schemes to remain consistent, with focussed improvements for the cohorts of residents with higher levels of needs, planned carers developments will also offer greater support to this group of our Dorset population.

Intermediate Care

We have continued BCF investment in home-based intermediate care (Recovery & Community Resilience, therapy-led reablement and Integrated Community Rehabilitation Team) and are maintaining targeted bed-based capacity where it adds most value. During 26/27 we will continue focussing on reducing hospital lengths of stays but speeding up discharges home with support, and increase independence levels so fewer residents require long-term packages. As a Dorset System as this work progressed we will review the nature and number of bed-based resources we require.

As referenced earlier in this plan, BCF funding invested in Community Reablement and Recovery & Community Resilience provision (HBIC offer) is supporting more people, and those with higher levels of need to get back home. Adult Social Care have deployed digital forms to these providers to enhance the Trusted Review process which is enabling Care Act Assessments to be completed in a more timely manner, reducing length of stay in HBIC services, and providing a more seamless experience for people being supported. Where people enter HBIC services with large care packages the Adult Social Care Team are prioritising support early in the pathway to understand needs, and explore therapy and equipment options. At the time of writing, average length of stay in HBIC is 20 days, with 40% of people fully independent of formal long-term care and support on discharge. On average care needs are reduced by 6 hours per week.

Supporting and Maintaining Independence, linked with Prevention

Disabled Facilities Grants and ICES continue to promote independence, reduce risks associated with falls and functional decline, reduce readmissions and enable more people to remain in the place they call home. During 25/26 to better manage the increasing demand we have utilised our Minor Adaptations offer, which includes changes such as installation of ramps, level access showers and fitting of handrails. 824 adaptations were completed. We received 600 referrals for DFGs, although a third of the referrals were addressed with advice and information. Dorset DFGs are available to all ages, with most of our complex cases, around 4 out of 5, supporting children and families to adapt their homes.

Technology Enabled Care (TEC) will continue to support safe independence, enable 'virtual care' elements within blended packages, and reduce reliance on in-person visits where appropriate. During 2025/26 c1430 installations of TEC were completed, examples include; cognitive support tools to provide reminders around daily routines and meal preparation that increases independence and avoids the need for traditional care, GPS-enabled devices with falls detection to enable individuals to go out independently. During the last year 96% of conversions to digital careline devices were completed – c2250 devices are now connected.

Through DIPPs, our partnership is responding early in the community, address practical barriers to discharge (e.g., through small grants and volunteer support) and stabilise crises before formal services are needed. This partnership is co-ordinating supporting at a local level across a range of support from welfare checks and carers support, responding to community and urgent referrals from health and social care professionals. Bereavement and social isolation support, along with housing and benefits advice are other examples of support, in addition to cleaning, food provision and transport services.

Our Carers offers continue support for Carers to access the tight information at the right time to make informed choices. Front facing services and online websites including Bridgit platform will support this. Bridgit has 25,230 users to date, 28,370 have created self-help plans, accessed 102,70 information support areas and 163 Carer Assessments submitted. We are transitioning to a new version with increased AI functionality during the coming year.

Universal services will support Carers in the community where they live, connect them to networks of support and services, preventing, delaying, and reducing the need for Social Care intervention. We will continue to expand our BCF Carers funding to support all ages of carers to extend the impact of the BCF, planning further upstream to prepare for changes and strengthen resilience. Examples include support for parents to plan for the independence of their child as they reach adulthood and beyond, and initiatives such as

MYTIME and The Hope Programme that provide emotional, social, and developmental support to young carers, helping mitigate the impact of caring responsibilities on education, health ,wellbeing, and life outcomes.

For 26/27 we are planning a 6-month pilot to support carers with through pre and post Hospital admission pathways. We intend to develop the service which will compliment the Home from Hospital service provided by existing VSCE services. The pilot will create a partnership to support a stress-free hospital experience for both the cared for person and their carers.

During 2025/26 Adult Social Care have introduced an enhanced approach to better manage front door demand and deploy more preventative approaches. A new Prevention and Early Intervention Team have been established to offer earlier more in-depth reviews of care and support needs to establish whether some form of reablement support would be appropriate. This ranges from low level equipment and TEC, community resources within VSCE networks local to the person, or goals focussed reablement for a short period to establish long term needs. For people who receive hands-on short-term reablement support, two thirds of people are reabled and do not need formal long-term support.

Currently this is funded outside of the BCF, but due to clear links to the BCF policy objectives, we have added to our plan as an Additional Local Authority funded scheme.

Longer-term Impacts

Finally, currently outside of this year's BCF schemes, but contributing to our aligned objectives, are our longer term capital plans for new Reablement Centres and the further expansion of Extra Care Housing. This will create additional capacity for preventative interventions and rehabilitation, and with ongoing sufficiency in the homecare market it will provide a more sustainable alternative to long-term residential care.

4. **Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.**

We will assure value for money (VfM) and raise productivity by:

- Targeting BCF spend at interventions with proven impact on prevention, independence and flow, such as DIPPs and Carers offers, home-based intermediate and long-term care, DFGs, Equipment and TEC. Closer working with community networks is key.
- Continuing to utilise the Dorset Care Framework 2 for contracting requirements, and deploying contract mechanisms such as standard rates, service categories and block contracting to improve price certainty, reduce brokerage activity, and deepen strategic relationships with providers to upskill the workforce to be able to support people with more complex and higher acuity conditions in the community.
- continuing to apply Fair Cost of Care principles during fee setting and commercial negotiations, maintaining the skillset and capability of our joint brokerage service.
- Using digital dashboards to share insights and intelligence, such as KPI monitoring of intermediate care, and scaling the approach across a range of opportunities where possible and appropriate to reduce manual processing and information/ data review, such as Trusted Review, Contract activity and management and referral co-ordination and care allocation.
- Where market conditions (e.g., pay related, inflation, equipment prices, transport costs) create pressure, we will use pooled-budget risk-share arrangements and demand-management measures (e.g. same/next-day delivery planning, assessment support, and improved scheduling) to protect value.

The Future Care diagnostic forecast material cash-releasing and non-cash benefits from improvements across the urgent and emergency care pathways that we expect to realise during 26/27 that will allow re-investment into different and new BCF initiatives during 27/28.

As we develop services within the BCF, we will refer to benchmarking data and insights. An example of this is our recent dialogue with four of the NSHE Community Rehab and Reablement Front Runners to understand their local tried and tested models.

5. **Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.**

Governance remains robust and joint. The Dorset Health & Wellbeing Board (HWB) oversees, signs off and monitors the BCF; delegated authority routes are used between meeting cycles with retrospective ratification at the next HWB.

Whilst the pan-Dorset Joint Commissioning Board (Dorset Council, BCP Council, NHS Dorset) has been paused due to local ICB re-organisation. Close working continues between Senior commissioning leads from the ICB and Council to manage day-to-day delivery and provide oversight and coordination.

At the time of writing, consideration is being given to how we can strengthen and expand the Health & Wellbeing Board Forward Plan to improve strategic oversight and development of Place, Community and Prevention initiatives, this will include programmes such as Neighbourhood Health, Intermediate Care, Place based partnerships and Children's Services initiatives.

The Future Care Transformation Programme has utilised the Dorset Information & Intelligence Service (DiiS) insights to enhance 'System Visibility' dashboards to monitor performance and trigger improvement actions in Urgent and Emergency Care. This demonstrates greater grip of operational services and enables a swifter route to escalation should there be issues that require action.

BCF Schemes are monitored at contract level by assigned commissioner / contract manager, where KPIs and budgets are monitored in line with set contract management procedures.

A joint audit of the BCF has recently been undertaken by independent auditors on behalf of NHS Dorset and the Council. While the final report is pending at the time of writing, the commissioning of an independent, partnership-wide audit demonstrates a clear commitment to robust governance, transparency, and effective oversight.